PROJECT high five
WAYNE METRO EARLY CHILDHOOD SERVICES
Begin Healthy
Connect to Resources
Engage in Learning
Build Confidence
Thrive by Five

Wayne Metro Early Childhood Services

Permission Form for Prescribed Medication

Site: _____ Date form received by the school: _____

Student: _____ Date of Birth: _____

Date medication received by school : _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:
{ } Tablet/capsule { } Liquid Inhaler { } Injection { } Nebulizer { } Other _____

Time and Dose to be given at school: _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____

_____

_____

Special Instructions: _____

Restrictions and/or important side effects: { } None anticipated { } Yes, Please describe:

_____

Special storage requirements: { } None { } Refrigerate

Start: { } Date form received Other dates: _____
Stop: { } End of school year Other date/duration: _____

Physician's Name: _____

Address: _____

Phone Number: _____ Fax: _____

Physician's Signature: _____ **Date:** _____

Physician's Stamp

To be completed by parent/guardian

I request that (name of child) _____ receive the above medication at school according to standard school policy and for the physician staff and school staff to share information needed to assist my child with his/her health and medication needs.

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Printed Name: _____ Telephone #_____